

Health Reform: Fraud and Abuse Workgroup
Monday, August 16, 2010
North Carolina Institute of Medicine, Morrisville
9:00a – 12:00p
Meeting Summary

Attendees:

Workgroup Members: Albert Koehler (co-chair), Tara Larson (co-chair), Robert Blum, Conor Brockett, Kenneth Burgess, Gene DeLaddy, Clarence Ervin, Jeff Horton, Cheryl Ann Mulloy, Rosalyn Pettyford, N. King Prather, Timothy Rogers

Staff: Kimberly Alexander-Bratcher, Thalia Fuller, Paul Mandsager, Sharon Schiro, Pam Silberman

Interested Persons: John Dervin, Frake Hunsel, Chris Skowronek, Tracy Hayes, Tiesha Pope

Welcome and Introductions

Albert P. Koehler, Deputy Commissioner/Director, Criminal Investigations Division, NC Department of Insurance, Co-Chair

Tara Larson, Chief Clinical Operations Officer, Division of Medical Assistance, Co-Chair

Mr. Kohler and Ms. Larson introduced themselves and welcomed the participants to the workgroup and ask the participants to introduce themselves.

Overview of health reform and structure of the health reform workgroups and workgroup charge

Pam Silberman, JD, DrPH, President & CEO, North Carolina Institute of Medicine

Dr. Silberman gave an overview presentation of the main provisions in the Patient Protection and Affordable Care Act (“Affordable Care Act or ACA”) and the structure of the health reform workgroups. Click here to view the presentation: [Health Reform overview](#).

Overview of Workgroup’s specific provisions from the Affordable Care Act and the Health Care and Education Reconciliation Act of 2010

Sharon Schiro, PhD, Vice President, North Carolina Institute of Medicine

Dr. Schiro gave a more detailed presentation of the health reform provisions related to Fraud and Abuse. Click here to view the presentation: [Workgroup overview](#). Click here to see the specific sections of the Affordable Care Act which the workgroup will review: [ACA Fraud and Abuse provisions](#).

Selected comments/questions:

- Q: Is the Medicaid Integrity funding federal or state? A: At moment, the funds are just federal.
- Ken Burgess discussed opportunities to pay for work many agencies are already providing around fraud and abuse.
- The recover payment period is extended to one year for federal payments, not the time to recover the funds.
- Q: How different is the Recovery Audit Contractor (RAC) program than what is already happening? A: There is already the ability to contract with Medicare RAC. Now the contracts are moving forward. There is currently an in-house program like RACs. The Department of Revenue (DOR) usually gets reimbursed before Medicaid in cases of recouping funds.
- Home health agencies need to be federally certified.
- There is a very short timeline for many programs. A good baseline of information would be a brief presentation that demonstrates what the state already has that deals with fraud and abuse programs. How do these activities interface with others? There are several different programs that the providers interact with around the issue and need to understand them. There is the possibility of joint reviews so that all funding sources may work together.
- There are both financial and personal fraud and abuse. When does poor or reckless care become a case of fraud and abuse?
- The group needs additional members to ensure that all perspectives are included.
- Mr. Koehler's organization prosecutes 100-150 individuals or cases. There are only 19 investigators statewide who deal with fraud and abuse, not just healthcare fraud. The Medicaid Fraud unit is being expanded.

Fraud and Abuse in NC: Gaps in surveillance and enforcement, and the need for integration

Albert P Koehler, Deputy Commissioner/Director, Criminal Investigations Division, NC Department of Insurance, Co-Chair

Mr. Koehler gave an overview of the Criminal Investigations Division and its implementation efforts focused on the federal health reform provisions. There are 19 investigators throughout the state. They receive an average of 60-70 referrals each week. All 38 district attorneys have different policies. Most attorneys will not prosecute if there is no financial loss to the insurance companies. North Carolina has the oldest fraud bureau in the country (65 years old) and serves as a model for many other states. Current estimates are that 15% of premiums are involved in fraud and abuse. There are cases in fraud and abuse from providers, insurance agents, and patients. There has been a doubling of insurance agents stealing premiums and embezzling. There have been increases in the number of small companies that receive premiums and hold them back rather than using the money to pay for employees' insurance premiums. It is a felony in NC, and the law requires that the employer pay all the bills incurred by the employee. There has been a large increase in fraud and abuse with the downturn in the economy.

Discussion:

- Durable Medical Equipment (DME) groups need representation on the workgroup.
- Recent fraud and abuse articles describing Iraq war versus Medicare, and claims around workers' compensation insurance
- Enforcement of abuse in background checks:
 - Whether or not to expunge juvenile records
 - National criminal background checks
 - Provisional bill for criminal background checks in adult day care homes.
 - System already in place in NC that does current and ongoing review for Emergency Medical Services

Tara Larson, Chief Clinical Operations Officer, Division of Medical Assistance, Co-Chair

Ms. Larson gave an overview of the Division of Medical Assistance implementation efforts focused on the federal health reform provisions. Click here to view the presentation: [Division of Medical Assistance](#). Ms. Larson noted that information was sent to all Medicaid recipients about fraud and abuse. The NC Division of Medical Assistance (DMA) is still awaiting guidance on how to implement some ACA provisions. The purpose of Program Integrity is to prevent problems rather than follow up and try to recover for errors. The PPACA legislation added 25 additional investigators to the Medicaid Investigation Unit within DMA.

Discussion:

- Frequency in Monitoring Tool helps identify providers that are outliers from peers for additional monitoring
- Medicaid Participation Agreements – disclosing information versus providing all the information
- Analytical software – runs paid claims and applies 9k algorithms looking at fraud and abuse across the spectrum of healthcare looking at outliers.
- Revised Provider Enrollment and Termination Rules – uncollected debt (failure to pay) related to state agencies/Medicaid, possibility to extend provisions to other databases, providers may switch names and ownership (all individuals with 5% ownership and management must disclose certain information)
- Data reporting:
 - access to databases (agencies, private, business agreements, etc.)
 - quarterly face-to-face meetings and conference calls on off months for all enforcement agencies
 - delays in processing
 - sharp increase in appeals based on new provider standard denials and terminations
 - may be cost-prohibitive for smaller companies
 - access is a major problem
 - new data management system (Medicaid Management Information System - MMIS) currently being updated, old system (Hewlett Packard

Electronic Data System) did not have level of reporting required or recommended by the legislation

- Definitions of fraud and abuse are legal issues
- Civil recoupment possible for acts that are not criminal but need to be resolved
- Workgroup should have presentation explaining what information is shared between agencies and how the outliers are notified of their status and resolution
- Details of implementation are some outstanding questions (reports on exclusion of providers, recoupments against all providers with same EIN numbers, offsetting future payments, etc)
- Workgroup should recommend additional training and education to provider associations (nursing homes, home health, etc.)

Discussion of Workgroup goals

Discussion:

- Missing workgroup members:
 - providers of durable medical equipment (DME)
 - local management entities (LME)
 - Critical Access Behavioral Health Agency (CABHA)
 - Medicaid Fraud Unit
 - Medicaid Provider Enrollment
 - Licensing Boards (medical, chiropractors, PTs)
 - Accreditation Commission for Health Care (national accreditation for many of these organizations)
 - someone representing recipient fraud (handled at the county level, county DSS director, County Commissioner's Association)
- Future group work:
 - continue to make sure that work continues to improve education, training, and enforcement
 - relationship between Medicaid audits and licensure
 - information sharing
 - state processes: (time delay), administrative code changes, rule changes
 - elder fraud and abuse

The next meeting of the Fraud and Abuse Workgroup will be Monday September 20, 2010 at the NCIOM offices in Morrisville at 9:00 AM.